STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195485	A. Building B. Wing	07/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Heritage Manor of Houma	852 Centurion Lane Houma, LA 70360

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on observations, interviews and record review, the facility failed to ensure care plan interventions were implemented for a resident at risk for falls for 1 (Resident #8) of 1 (Resident #8) sampled residents investigated for accidents. Findings:Review of Resident #8's Care Plan, initiated on 05/19/2025, revealed, in part, Resident #8 was at risk for falls related to impaired mobility and impaired cognition. Further review revealed fall interventions included brake extenders with highlighted tape added to Resident #8's wheelchair. Observation on 07/28/2025 at 11:50AM revealed Resident #8's wheelchair did not have brake extenders with highlighted tape. Observation on 07/29/2025 at 2:15PM revealed Resident #8's wheelchair did not have brake extenders with highlighted tape. Observation on 07/30/2025 at 1:46PM revealed Resident #8's wheelchair did not have brake extenders with highlighted tape. Observation on 07/31/2025 at 12:14PM, with S10Licensed Practical Nurse (LPN) present revealed Resident #8's wheelchair did not have brake extenders with highlighted tape. In an interview on 07/31/2025 at 12:15PM, S10LPN confirmed Resident #14 did not have wheelchair brake extenders with highlighted tape. In an interview on 07/31/2025 at 2:00PM, S1Administrator was presented with the above mentioned findings and offered no further explanation to dispute the above mentioned deficient practice.

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. Based on observations, interviews, and record reviews, the facility failed to ensure a resident's indwelling urinary catheter collection bag was not touching the floor for 1 (Resident #67) of 1 (Resident #67) sampled residents investigated for urinary catheter care and Urinary Tract Infections (UTI). Findings: Review of Resident #67's Minimum Data Set with an Assessment Reference Date of 03/13/2025 revealed, in part, Resident #67 had an indwelling catheter and was dependent for all care. Review of Resident #67's July 2025 physician's orders revealed, in part, an order dated 10/17/2024 for an indwelling Foley catheter. Observation on 07/28/2025 at 11:04AM revealed Resident #67 had an indwelling catheter in place. Further observation revealed Resident #67's indwelling urinary catheter collection bag was hanging off the side of the bed touching the floor. Observation on 07/29/2025 at 12:00PM revealed Resident #67's indwelling urinary catheter collection bag was hanging off the side of the bed touching the floor. In an interview on 07/29/2025 at 2:16PM S4Certified Nursing Assistant (CNA) indicated Resident #67's indwelling urinary catheter collection bag was touching the floor and should not have been. In an interview on 07/31/2025 at 2:00PM, S1Administrator was presented with the above mentioned findings and offered no further explanation to dispute the above mentioned deficient practice.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. Based on observation, interviews, and record reviews, the facility failed to:1. Ensure the correct enteral feeding (a type of liquid nutritional supplement that is typically given through a tube directly inserted into the stomach) formula was infused as ordered for 1 (Resident #13) of 1 (Resident #13) sampled residents investigated for enteral feeding maintenance. Findings:Review of the facility's Tube (Enteral) Feedings policy and procedure, dated 06/1994, with a revision date of 12/2015, revealed, in part, all enteral feedings will be administered in accordance with verified medical necessity and physician's orders. Review of Resident #13's July 2025 physician's orders revealed, in part, an order dated 07/23/2025 for Resident #13 to receive Nutren 2.0 (a type of enteral feeding) at 50 milliliters (mL) per hour for twenty-four hours per day. Observation on 07/30/2025 at 10:45AM revealed Resident #13 had Isosource 1.5 (a type of enteral feeding) infusing at a rate of 50 mL per hour. Further observation revealed the above mentioned Isosource 1.5 had an infusion start date and time of 07/30/2025 at 10:00PM labeled on the enteral feeding bag. In an interview on 07/30/2025 at 11:10AM, S10Licensed Practical Nurse (LPN) indicated Resident #13 had received the incorrect enteral feeding. S10LPN further indicated Resident #13 should have received Nutren 2.0 as ordered. In an interview on 07/30/2025 at 11:54AM, S2Director of Nursing (DON) confirmed Resident #13 had been administered the incorrect enteral feeding formula. In an interview on 07/31/2025 at 2:00PM, S1Administrator was presented with the above mentioned findings and offered no further explanation to dispute the above mentioned deficient practice.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. Based on observations, interviews, and record reviews, the facility failed to ensure a resident's oxygen tubing was maintained in a sanitary manner per facility policy for 1 (Resident #14) of 1 (Resident #14) sampled residents reviewed for respiratory care. Findings:Review of the facility's Infection Control Oxygen Equipment Cleaning policy and procedure, dated 04/2006, with a revision date of 03/2018, revealed, in part, oxygen tubing and cannulas should be replaced every 7 days. Review of Resident #14's July 2025 Physician's orders revealed, in part, an order dated 06/27/2025 for Resident #14 to receive oxygen at 2 liters (L) by nasal cannula continuously. Observation on 07/28/2025 at 11:14AM revealed Resident #14's oxygen tubing had a date of 07/06 written on the tubing. Observation on 07/29/2025 at 2:30PM revealed Resident #14's oxygen tubing had a date of 07/06 written on the tubing. In an interview on 07/30/2025 at 11:01AM, S11Licensed Practical Nurse (LPN) indicated Resident #14's oxygen tubing should have been changed out weekly. In an interview on 07/31/2025 at 2:00PM, S1Administrator was informed of the above and offered no explanation to dispute the above mentioned deficient practice.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations, interviews, and record reviews, the facility failed to:1. Ensure staff wore hair restraints when preparing food in the facilities kitchen (S12Dietary Manager's Trainer, S13Dietary Aide, and S14Dietary Aide); 2. Ensure food stored in the facility's refrigerators were labeled as required (Refrigerator e, Freezer f);3. Ensure shelving in the facility's kitchen was kept in a sanitary manner;4. Ensure the facility's staff practiced appropriate hand hygiene (S15Dietary Aide and S12Dietary Manager's Trainer);5. Ensure chemicals were kept out of food service areas;6. Ensure utensils were stored in a sanitary manner when not in use; and,7. Ensure cartons of nutritional supplement was stored per a manufacturer's guideline and was not available for resident consumption (Medication Cart c, Medication cart d).The deficient practice was identified for 3 of 3 days observed for food preparation and storage requirements. Findings: 1. Review of the facility’s Employee Work Practices policy and procedure, last revised in 05/2018, revealed, in part, food service employees were to wear a clean hat or other hair restraint in the food production area; and or a beard restraint. Observation on 07/29/2025 at 11:15AM, revealed S12Dietary Manager’s Trainer had a section of hair to the left and right of her forehead styled and unrestrained from her hair net. Further observation revealed S13Dietary Aide had a mustache with no facial hair restraint in place. Observation on 07/29/2025 at 11:40AM, revealed S14Dietary Aide had a beard with no facial hair restraint in place, and S13Dietary Aide had a mustache with no facial hair restraint in place. In an interview on 07/29/2025 at 11:48AM, S12Dietary Manager’s Trainer indicated all hair should be restrained in a hair net. S12Dietary Manager’s Trainer confirmed anyone with facial hair should have a facial hair restraint. 2. Review of the facility's Food Storage Labeling policy and procedure, last revised on 05/2018, revealed, in part, all foods that are prepared in the facility should be labeled with the name of the food and the date of storage. Observation on 07/28/2025 at 09:01AM, revealed a three-fourths full container of Italian dressing was in Refrigerator “e” and was not labeled with an opened date. In an interview on 07/29/2025 2:56PM, S1Administrator indicated the above-mentioned finding was an oversight habit that should have not happened. Observation of Freezer “f” on 07/30/2025 at 10:39AM revealed a pitcher of an unknown light brown liquid was not labeled with the contents of the pitcher and/or the date of storage. In an interview on 07/30/2025 at 10:30AM, S2Director of Nursing indicated all items in Freezer “f” should be labeled and dated. In interview on 07/30/2025 at 10:34AM, S1Administrator indicated the above mentioned findings should not have been present. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. Observation on 07/28/2025 at 09:01AM, revealed an unknown gray dusty-like substance was present on the shelf on top of the kitchen’s 3-compartment sink. Observation on 07/29/2025 at 11:38AM revealed the shelf next to the kitchen’s food prep sink had nine buckets and five metal containers sitting on a shelf. Further observation revealed the above mentioned shelf was covered with a grayish, dusty-like, slightly sticky substance. In an interview on 07/29/2025 at 11:40AM, S12Dietary Manager’s Trainer indicated the facility’s staff should clean all surfaces every week and the above mentioned shelves should have been clean. In an interview on 07/29/2025 2:56PM, S1Administrator indicated the above mentioned finding was an oversight habit that should have not happened. 4. Observation on 07/29/2025 at 11:20AM revealed, while checking food temperatures, S15Dietary Aide dropped the thermometer into the food. Further observation revealed, S15Dietary Aide then stuck her ungloved hand into the food to retrieve the thermometer. Observation on 07/29/2025 at 11:43AM, revealed S12Dietary Manager’s Trainer opened a trash can lid with her ungloved hands to throw a spatula away, opened the trash can lid again with her ungloved hands to throw away another item, did not perform hand hygiene, and then handed the dietary staff serving food to residents a stack of clean plates. In interview on 07/30/2025 at 10:34AM, S1Administrator indicated he had reviewed the surveillance footage from the kitchen and confirmed the surveyor’s observations of S12Dietary Manager Trainer, which were deficient practice. 5. Observation on 07/29/2025 at 11:23AM revealed a cleaning bucket with sanitizing solution was next to desserts and salads that were on the serving table behind the kitchen’s steam table. In an interview on 07/29/2025 at 11:36AM, S12Dietary Manager’s Trainer indicated the red bucket with the liquid and towel contained sanitizer. S12Dietary Manager’s Trainer further indicated she did not think this was a chemical. In an interview on 07/29/2025 2:56PM, S1Administrator indicated the above mentioned finding was an oversight habit that should have not happened. 6. Review of the Louisiana Administrative Code Title 51: Public Health-Sanitary Code, last revised in 02/2025 revealed, in part, during pauses in food preparation or dispensing, utensils shall be stored with their handles above the top of the food. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 07/29/2025 at 11:28AM, S16Dietary Aide was using tongs to serve chicken with ungloves hands. Further observation revealed S16Dietary Aide then laid the tongs with the area she touched with her ungloved hands directly on top of the chicken. Observation on 07/29/2025 at 11:33AM, S15Dietary Aide was using tongs to serve biscuits with ungloved hands. Further observation revealed S15Dietary Aide then laid the tongs with the area she touched with her ungloved hands directly on top of the biscuits. In an interview on 07/29/2025 2:56PM, S1Administrator indicated the above mentioned findings were an oversight habit that should have not happened. 7. Review of Med Plus 2.0 nutritional supplement's directions revealed, in part, the product should be used within 4 hours of opening if not refrigerated. Observation on 07/31/2025 at 12:49PM revealed an opened unrefrigerated carton of Med Plus 2.0 nutritional supplement on Medication Cart “c”. Further observation revealed the above mentioned carton did not have an opened date and/or time written on it. Observation on 07/31/2025 at 12:51PM revealed an opened unrefrigerated carton of Med Plus 2.0 nutritional supplement on Medication Cart “d”. Further observation revealed the above mentioned carton did not have an opened date and/or time written on it. In an interview on 07/31/2025 at 1:04PM, S10Licensed Practical Nurse (LPN) confirmed she was assigned to Medication cart “c”. S10LPN further indicated the above mentioned supplement was opened on 07/31/2025 at 7:00AM, not refrigerated, and available for resident consumption. S10LPN further indicated she did not know the supplement should have been used within 4 hours of opening if not refrigerated. In an interview on 07/31/2025 at 1:05PM, S11LPN confirmed she was assigned to Medication cart “d”. S11LPN further indicated the above mentioned supplement was opened on 07/31/2025 at 6:00AM, not refrigerated, and available for resident consumption. In an interview on 07/31/2025 at 2:00PM, S1Administrator was presented with the above mentioned findings and offered no further explanation to dispute the above mentioned deficient practice.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on observations, interviews and record reviews, the facility failed to ensure a resident's Electronic Medical Record (EMR) was accurately documented for 5 (Resident #8, Resident #13, Resident #14, Resident #53, Resident #110) of 46 (Resident #1, Resident #2, Resident #3, Resident #4, Resident #5, Resident #6, Resident #8, Resident #9, Resident #10, Resident #11, Resident #12, Resident #13, Resident #14, Resident #16, Resident #18, Resident #19, Resident #23, Resident #26, Resident #32, Resident #39, Resident #42, Resident #53, Resident #55, Resident #56, Resident #60, Resident #62, Resident #63, Resident #67, Resident #68, Resident #69, Resident #74, Resident #80, Resident #81, Resident #85, Resident #87, Resident #89, Resident #93, Resident #95, Resident #108, Resident #110, Resident #114, Resident #115, Resident #118, Resident #119, Resident #120, and Resident #121) sampled residents reviewed for accurate medical record documentation. Findings:Resident #8 Review of Resident #8’s Care Plan, initiated on 07/15/2025, revealed, in part, Resident #8 should have brake extenders with highlighted tape added to her wheelchair due to recent falls. Review of Resident #8’s July 2025 Electronic Task Completion List revealed, in part, Resident #8 was documented as having had all of her safety devices and special equipment in place per the plan of care on the following dates: - 07/28/2025 at 10:58AM by S5Certified Nursing Assistant (CNA); - 07/28/2025 at 6:27PM by S9CNA; - 07/29/2025 at 5:06AM by S9CNA; - 07/29/2025 at 7:56AM by S5CNA; - 07/29/2025 at 2:53AM by S5CNA; - 07/30/2025 at 5:44AM by S8CNA; - 07/30/2025 at 8:11AM by S6CNA; - 07/30/2025 at 9:09PM by S7CNA; - 07/30/2025 at 10:13AM by S6CNA; and, - 07/31/2025 at 11:14AM by S4CNA. Observation on 07/28/2025 at 11:50AM revealed Resident #8’s wheelchair did not have brake extenders with highlighted tape. Observation on 07/29/2025 at 2:15PM revealed Resident #8’s wheelchair did not have brake extenders with highlighted tape. Observation on 07/30/2025 at 1:46PM revealed Resident #8’s wheelchair did not have brake extenders with highlighted tape. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 07/31/2025 at 12:14PM, with S10Licensed Practical Nurse (LPN) present, revealed Resident #8’s wheelchair did not have brake extenders with highlighted tape. In an interview on 07/31/2025 at 12:08PM, S4CNA indicated she was assigned to care for Resident #8. S4CNA indicated she documented all safety precautions and/or interventions were in place for Resident #8 but did not know what all of the safety precautions were. In an interview on 07/31/2025 at 12:15PM, S10LPN confirmed Resident #8 did not have wheelchair brake extenders with highlighted tape on Resident #8’s wheelchair. In an interview on 07/31/2025 at 2:00PM, S1Administrator was presented with the above mentioned findings and offered no explanation or evidence to dispute the above mentioned deficient practice. Resident #13 Review of Resident #13’s Administration History Report revealed, in part, S3LPN documented on 07/30/2025 at 9:02AM that Resident #13 had received enteral feeding formula Nutren 2.0 as ordered. Observation on 07/30/2025 at 10:45AM revealed Resident #13 had Isosource 1.5 (a type of enteral feeding) infusing at a rate of 50 mL per hour. Further observation revealed the above mentioned Isosource 1.5 had an infusion start date and time of 07/30/2025 at 10:00PM labeled on the enteral feeding bag. In an interview on 07/30/20250at 11:10AM, S10LPN indicated her documentation that Resident #13 received Nutren 2.0 enteral feed on 07/30/2025 at 9:02AM was inaccurate and should not have been. In an interview on 07/30/2025 at 11:54AM, S2Director of Nursing (DON) confirmed Resident #13’s enteral feeding bag was labeled with the incorrect date. In an interview on 07/31/2025 at 2:00PM, S1Administrator was presented with the above mentioned findings and offered no explanation or evidence to dispute the above mentioned deficient practice. Resident #14 Review of Resident #14’s July 2025 Electronic Task Completion List revealed, in part, Resident #14’s oxygen tubing was documented as having been changed on the following dates: - 07/12/2025 at 6:27AM by S3LPN; - 07/19/2025 at 6:22AM by S3LPN; and, - 07/26/2025 at 6:36AM by S3LPN. Observation on 07/28/2025 at 11:14AM revealed Resident #14's oxygen tubing had a date 07/06 written on the tubing. Observation on 07/29/2025 at 2:30PM revealed Resident #14’s oxygen tubing had a date 07/06 written on the tubing. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 07/30/2025 at 11:01AM, S11LPN indicated Resident #14’s oxygen tubing should have been changed out weekly. S11LPN further indicated she did not know when the last time Resident #14’s oxygen tubing was changed out. In an interview on 07/31/2025 at 2:00PM, S1Administrator was presented with the above mentioned findings and offered no explanation or evidence to dispute the above mentioned deficient practice. Resident #53 Review of the facility’s Advance Directives policy and procedure, with a revision date of 07/2015, revealed, in part, if an Advance Directive has been completed, the admitting staff must obtain a copy of the Advance Directive so it may be placed in the medical record. Further observation revealed the admitting staff will document in the medical record and will notify the attending physician verbally and obtain a physician’s order if the resident has executed an Advance Directive. Review of Resident #53’s July 2025, electronic record revealed, in part, an order for Resident #53 to be a Full Code (which indicated in the event a resident presented with no pulse or no breath, medical interventions would take place). Review of Resident #53’s paper medical record revealed, in part, an Advanced Directive which indicated Resident #53’s code status was Do Not Resuscitate (DNR) (which indicated in the event a resident presented with no pulse and/or no breath, medical interventions would not take place). In an interview on 07/28/2025 12:29PM, Resident #53 indicated she wanted DNR to be her code status. In an interview on 07/28/2025 12:41PM, S1Administrator and S2Director of Nursing indicated when a code blue was called the actual chart and advance directive paper form was used. In an interview on 07/30/2025 9:45AM, S11Licensed Practical Nurse indicated the actual paper chart was used to determine a resident’s code status. In an interview on 07/30/2025 9:52AM, S18Licensed Practical Nurse indicated the actual paper chart was used to determine a resident’s code status. In an interview on 07/31/2025 11:15 AM S17Licensed Practical Nurse indicated the actual paper chart was used to determine as resident’s code status. In an interview on 07/31/2025 11:43 AM S11Licensed Practical Nurse indicated Resident #53’s Full Code status order in the July 2025, physician’s orders was incorrect. In an interview on 07/31/2025 12:07 PM S2(DON) indicated Resident #53's full code status in the computer was incorrect. In an interview on 07/31/2025 12:11 PM S1(NFA) indicated Resident #53's full code status in the computer was incorrect. Resident #110 Review of Resident #110’s Bathing Care Task log revealed, in part, no documented evidence, (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #110 received and/or refused a bath/shower on 07/02/2025, 07/09/2025, 07/14/2025, 07/21/2025, and 07/28/2025. There was no documented evidence, and the facility did not present any documented evidence, staff documented if Resident #110 had received and/or refused a bath/shower on 07/02/2025, 07/09/2025, 07/14/2025, 07/21/2025, and 07/28/2025. In an interview on 07/30/2025 at 3:30PM, S2DON indicated Resident #110 was scheduled to have baths on Mondays, Wednesdays, and Fridays. S2DON further indicated S19CNA should have documented when Resident #110 received a bath/shower on the above mentioned dates.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195485	A. Building B. Wing	07/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Heritage Manor of Houma	852 Centurion Lane Houma, LA 70360

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observations, interviews, and record reviews, the facility failed to:1. Post the appropriate signage for contact isolation on a resident's door (Resident #4, Resident #5);2. Ensure Certified Nursing Assistants (CNAs) wore proper personal protective equipment (PPE) while performing incontinence care on a resident on Enhanced Barrier Precautions (EBP) (Resident #67); and,3. Ensure CNAs completed hand hygiene during incontinence care (Resident #67).This deficient practice was identified for 3 (Resident #4, Resident #5, Resident #67) of 3 (Resident #4, Resident #5, Resident #67) sampled residents investigated for infection control surveillance. Findings:1. Review of the facility’s Procedure for Isolation: Isolation Precautions policy and procedure, dated 04/2006 and revised on 04/2014, revealed, in part, appropriate signage (isolation precaution signage) should be posted outside the resident’s door. Resident #4 Review of Resident #4’s July 2025 physician’s orders revealed, in part, an order for strict contact isolation precautions for Resident #4. Review of Resident #4’s Care Plan, initiated on 07/19/2025, revealed, in part, Resident #4 had a urinary tract infection (UTI) related to Extended-Spectrum Beta-Lactamases (ESBL) (a type of UTI that is caused by an ESBL bacteria, which is a bacteria resistant to many common antibiotics, making treatment more challenging). Observation on 07/28/2025 at 9:31AM revealed no contact isolation precaution signage was posted on Resident #4’s door. Resident #5 Review of Resident #5’s July 2025 physician’s orders revealed, in part, strict isolation for contact precautions. Review of Resident #5’s Care Plan, initiated on 07/26/2025, revealed, in part, Resident #5 was on contact isolation due to ESBL in her urine. Observation on 07/28/2025 at 9:28AM revealed no contact isolation precaution signage was posted on Resident #4’s door. In an interview on 07/28/2025 at 10:15AM, S2Director of Nursing (DON) confirmed Resident #4 and Resident #5 were on contact isolation due to ESBL in their urine. S2DON confirmed Resident #4 and Resident #5 should have had appropriate isolation signage posted on the outside of their door and they did not have the required signage posted. 2. Review of the facility’s Enhanced Barrier Precautions (EBP) policy and procedure, dated 01/2023, and revised on 03/2024, revealed, in part, EBP required the use of gown and gloves for high contact resident care activities such as urinary catheter care and incontinence care. Further review revealed EBP were indicated for residents with indwelling medical devices such as a urinary catheter. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195485	A. Building B. Wing	07/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Heritage Manor of Houma	852 Centurion Lane Houma, LA 70360

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #67’s Care Plan, initiated on 09/16/2024 revealed, in part, Resident #67 was on EBP due to Resident #67’s indwelling urinary catheter. Observation on 07/29/2025 at 2:05PM revealed S4CNA entered Resident #67’s room to assist in performing catheter care and incontinence care. S4CNA did not put on a gown before she began to assist in the performance of Resident #67’s catheter care and incontinence care. S4CNA helped to remove Resident #67’s soiled brief, turned Resident #67, and placed a clean adult brief on Resident #67 without wearing a gown. In an interview on 07/29/2025 at 2:16PM, S4CNA indicated she did not think Resident #67 was on any barrier precautions. In an interview on 07/29/2025 at 2:30PM, S11Licensed Practical Nurse indicated Resident #67 was on EBP which included staff wearing gowns and gloves. In an interview on 07/31/2025 at 2:00PM, S1Administrator was presented with the above mentioned findings and offered no explanation to dispute the above mentioned deficient practice. 3. Review of the facility’s Hand Hygiene policy and procedure, dated 12/2011, and revised on 01/2024, revealed, in part, the purpose of hand hygiene was to cleanse hands to prevent transmission of infection or other conditions. Further review revealed hand hygiene should have been performed between all contact with residents and before and after applying gloves. Review of the Centers for Disease Control and Prevention (CDC)’s October 2022 Guidelines for Hand Hygiene in Health-Care Settings revealed, in part, staff should decontaminate their hands if moving from a contaminated body site to a clean body site during patient care. Observation on 07/29/2025 at 2:05PM revealed S5CNA entered Resident #67’s room to perform incontinence care. S5CNA then removed Resident #67's soiled adult brief, performed catheter care, cleaned Resident #21’s buttock area, and placed a clean adult brief on Resident #21 without changing gloves or performing hand hygiene. S5CNA then disposed of Resident #21's soiled adult brief into the trash. S5CNA then covered Resident #67 back up with her bedding while wearing the same gloves used to perform the above mentioned observation. In an interview on 01/14/2025 at 2:25PM, S5CNA confirmed she did not change gloves and perform hand hygiene after handling Resident #67’s soiled adult brief and/or after cleaning Resident #67’s soiled body and should have. In an interview on 07/31/2025 at 2:00PM, S1Administrator was presented with the above mentioned findings and offered no explanation to dispute the above mentioned deficient practice.